NAME OF PROVIDER OR SUPPLIER BRAKEBILL NURSING HOME INC. (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.) (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
BRAKEBILL NURSING HOME INC. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFING INFORMATION) N 002 1200-8-6 No Deficiencies During annual Licensure survey and complaint survey #28927 conducted on November 14-16, 2011, at Brakebill Nursing Home, no deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes.	NAME OF D	2014252 02 0125	TN4702				11/	11/16/2011	
N 002 N 002 1200-8-6 No Deficiencies N 002	NAIVIE OF P	ROVIDER OR SUPPLIER							
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) N 002 1200-8-6 No Deficiencies During annual Licensure survey and complaint survey #28927 conducted on November 14-16, 2011, at Brakebill Nursing Home, no deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes.	BRAKEB	ILL NURSING HOME	INC.						
During annual Licensure survey and complaint survey #28927 conducted on November 14-16, 2011, at Brakebill Nursing Home, no deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLET DATE	
survey #28927 conducted on November 14-16, 2011, at Brakebill Nursing Home, no deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes.	N 002	1200-8-6 No Deficiencies		N 002					
on of Health Care Facilities TITLE ADDISANT A.C. INST. (6) DATE (6) DATE		survey #28927 con- 2011, at Brakebill N were cited in relatio	ducted on Novemb lursing Home, no o on to the complaint	per 14-16, deficiencies under					
in of Health Care Facilities TITLE ADDISANT ACT INSTALL (X6)DATE (X6)DATE					And the state of t				
on of Health Care Facilities TITLE Assistant activista									
on of Health Care Facilities TITLE Assistant ach insta						*			
on of Health Care Facilities TITLE Assistant ach insta							,		
on of Health Care Facilities TITLE Assistant ach instr									
on of Health Care Facilities TITLE ADDISTANT ach inst. (X6) DATE									
on of Health Care Facilities TITLE ADDISTANT ach insta				ден перепо недалоска закана меса					
1 THE TOTAL THE PROPERTY OF TH	on of Hea	Ith Care Facilities				TITLE ADDI	start ach	inste	
RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE WILL BLAKELLY WILKERSON 11/30	RATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESE	NTATIVE'S SIGN	NATURE YALL	MI Brahelle W	lilkuson	11/301	